Pediatric Sleep Questionnarie

Patients under 18 years of age

Last Name: _____ First Name: _____ Age: _____ Date: _____

Please answer on behalf of your child for the past month.
If you don't know, circle "?"

While sleeping, does your child...

1. snore more than half the time? ..... Yes / No / ?
2. always snore? ..... Yes / No / ?
3. snore loudly? ..... Yes / No / ?
4. have trouble breathing or struggle to breathe? ..... Yes / No / ?
5. have "heavy" or loud breathing? ..... Yes / No / ?
6. have you ever seen your child stop breathing during the night? ..... Yes / No / ?

Does your child...

7. tend to breathe through the mouth during the day? ..... Yes / No / ?
8. have a dry mouth on waking up in the morning? ..... Yes / No / ?
9. occasionally wet the bed? ..... Yes / No / ?
10. wake up feeling unrefreshing in the morning? ..... Yes / No / ?
11. have a problem with sleepiness during the day? ..... Yes / No / ?
12. is it hard to wake your child up in the morning? ..... Yes / No / ?
13. does your child wake up with headaches in the morning? ..... Yes / No / ?
14. did your child stop growing at a normal rate at any time since birth? ..... Yes / No / ?
15. is your child overweight? ..... Yes / No / ?

My child often...

16. does not seem to listen when spoken to directly ..... Yes / No / ?
17. has difficulty organising task and activites ..... Yes / No / ?
18. is easily distracted by extraneous stimuli ..... Yes / No / ?
19. fidgets with hands or feet or squirms in seat ..... Yes / No / ?
20. is 'on the go' or often acts as if 'driven by a motor' ..... Yes / No / ?
21. interrupts or interdes on others (e.g. butts into conversations or games) ..... Yes / No / ?

Reference: Chervin RD1, Hedger K, Dillon JE, Pituch KJ. Pediatric sleep questionnaire (PSQ): validity and reliability of scales for sleep-disordered breathing, snoring, sleepiness, and behavioral problems. Sleep Med. 2000 Feb 1;1(1):21-32.